

MONTANA LEGISLATIVE HISTORY

Chapter 541 19 89

Bill H _____ S 272 Original bill & history C

H. Committee on Human Services & Aging

Hearing Date(s) Mar 08 ☒ C

Mar 15 ☒ C

_____ ☐ C

_____ ☐ C

Date Out Mar 16 ☒ C

S. Committee on Public Health, Welfare & Safety

Hearing Date(s) Feb 13 ☒ C

Feb 15 ☒ C

_____ ☐ C

_____ ☐ C

Feb 16 ☒ C

Did this bill originate in an interim committee? ☐ Yes ☐ No

Committee _____

Report _____

SENATE FINAL STATUS

3/23	RETURNED TO SENATE WITH GOVERNOR'S AMENDMENTS		
3/30	2ND READING GOVERNOR'S AMENDMENTS		
	CONCURRED	50	0
4/01	3RD READING GOVERNOR'S AMENDMENTS		
	CONCURRED	48	0
	TRANSMITTED TO HOUSE		
4/05	2ND READING GOVERNOR'S AMENDMENTS		
	CONCURRED	97	0
4/06	3RD READING GOVERNOR'S AMENDMENTS		
	CONCURRED	98	1
	RETURNED TO SENATE		
4/13	SIGNED BY PRESIDENT		
4/17	SIGNED BY SPEAKER		
4/18	TRANSMITTED TO GOVERNOR		
4/21	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 606	EFFECTIVE DATE:	10/01/89

SB 272 INTRODUCED BY KEATING, ET AL.
 EXTEND SUNSET PROVISION OF THE 1987 MENTAL HEALTH
 INVOLUNTARY COMMITMENT ACT

1/27	INTRODUCED		
1/27	REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY		
2/13	HEARING		
2/16	COMMITTEE REPORT--BILL NOT PASSED		
2/16	ADVERSE COMMITTEE REPORT ADOPTED	33	7
2/17	RECONSIDERED ADOPTION OF ADVERSE		
	COMMITTEE REPORT	39	11
2/18	2ND READING PASSED AS AMENDED	42	2
2/21	3RD READING PASSED	47	3
	TRANSMITTED TO HOUSE		
2/22	REFERRED TO HUMAN SERVICES & AGING		
3/08	HEARING		
3/16	COMMITTEE REPORT--BILL CONCURRED AS AMENDED		
3/27	2ND READING CONCURRED	87	6
3/29	3RD READING CONCURRED	89	8
	RETURNED TO SENATE WITH AMENDMENTS		
4/01	2ND READING AMENDMENTS CONCURRED	48	0
4/04	3RD READING AMENDMENTS CONCURRED	49	0
4/08	SIGNED BY PRESIDENT		
4/08	SIGNED BY SPEAKER		
4/10	TRANSMITTED TO GOVERNOR		
4/14	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 541	EFFECTIVE DATE:	4/14/89

SB 273 INTRODUCED BY KEATING, ET AL.
 CONSTITUTIONAL AMENDMENT TO ALLOW THE GOVERNOR TO
 REMOVE A MEMBER OF THE BOARD OF REGENTS OF
 HIGHER EDUCATION

1/27	INTRODUCED		
1/27	REFERRED TO JUDICIARY		
2/02	HEARING		
	DIED IN COMMITTEE		

would have a permanent residence and supervision over trainees.

Senator Norman asked that in addition to all the powers and duties conferred in this chapter what additional language would resolve the matter. Mr. Brazier stated that the Board has attempted to adopt rules.

Mary Lou Garrett, Board of Hearing Aid Dispensers, explained that the reason they are asking for this is for consumer protection. They would like the authority to order restitution to unsatisfied customers. She stated the bill would give them a negotiation area.

Senator Hager asked Tom Gomez to explain amendments requested by Senator Eck. The amendments were studied by the committee.

Recommendation and Vote: Senator Rasmussen made a motion that the amendments be adopted. Senators in favor, 7; opposed, 0.

Senator Lynch observed that he was not sure the bill was looking out for the consumer. He is concerned that this bill goes further than just demanding a refund for consumers.

Senator Hager asked if there was any interest in cutting the bill down. Ms. Garrett stated the Board gave her permission to say they would delete Sections 6 and 7.

Senator Rasmussen stated that those amendments speak to what Senator Lynch discussed. He added that in the interest of seeing the bill passed, he would move that Sections 6 and 7 be struck. The motion was made by Senator Rasmussen to strike Sections 6 and 7 except the language inserted "passed the written". Senators in favor, 7; opposed, 0.

Further discussion was had regarding related devices, and regarding refunds.

Senator Rasmussen moved that SB 299 DO PASS AS AMENDED. Senators in favor, 2 (Rasmussen, Lynch); opposed, 5. It was recommended to reverse the wording to SB 299 AS AMENDED DO NOT PASS.

HEARING ON SENATE BILL 272

Presentation and Opening Statement by Sponsor: Senator Tom

Keating, Senate District #44, advised that in the last session an intermediate mental health involuntary commitment law was passed with a Sunset date. SB 272 is a repealer of that Sunset in order to continue the law in the statutes. He stated that this law provides that those at a low level of mental illness could be committed locally for a period of thirty days in order to avoid a severe mental illness situation. It would be a tool that could be used in a community for early treatment. He stated that the law has not been used often, and is more like a safety valve. It became effective in October, 1987, and has been used about six times during that time. He said no reports of misuse have surfaced, and he recommended that the committee pass SB 272 to rescind the Sunset date and to allow this safety valve to remain in the statutes for use when and if needed.

List of Testifying Proponents and What Group they Represent:

Steve Waldron, Executive Director, Montana Council of
Mental Health Centers
John Thorson, Mental Health Association of Montana

List of Testifying Opponents and What Group They Represent:

Kelly Moorse, Director, Board of Visitors
Mary Gallagher, Staff Attorney, Board of Visitors
Tom Posey, Montana Alliance for the Mentally Ill

Testimony:

Steve Waldron stated that the bill relates to the community commitment law that was passed in the last legislative session. It uses a lower standard to classify someone as seriously mentally ill. This category was developed for a mentally ill person who needs treatment, is deteriorating, but does not meet the current legal definitions necessary for commitment. He told of one instance where this law prevented an individual from going to jail or being institutionalized. He stated that if this bill is passed repealing the Sunset, he would put together some sort of training material so that staff would know what to do. He stated the Sunset was put on because of the fear the law would be overused, and now the law is being criticized because it is under utilized. He pointed out that a number of states have gone into similar outpatient commitment laws and they seem to be working quite well.

John Thorson, representing the Mental Health Association of Montana, stated they support this legislation. They acknowledged some problems with the legislation that was alluded to, stating it is complex and has not been used very often. However, they feel that two years is too short a period to make a final evaluation. They do think it provides an additional method for local officials to deal with the problems of the mentally ill. He urged the committee to extend this legislation by passing SB 272.

Kelly Moore, Director of the Mental Disabilities Board of Visitors, advised that the 1987 legislature requested the Board to complete a report on the outpatient commitment. That was part of their annual report and she provided the committee with copies of the section pertaining to outpatient commitment (Exhibit #1).

Mary Gallagher advised that she is a staff attorney with the Mental Disabilities Board of Visitors legal services program. She read and presented her written testimony to the committee (Exhibit #2). She urged the committee to vote against this bill.

Tom Posey, representing the Montana Alliance for the Mentally Ill, stated he is tired of coming before the legislature every two years and trying to defeat a bill that wants to take away part of his liberties strictly because he is mentally ill. He is totally opposed to the lessening of the standards of imminent danger. They are the only standards that are proven to have the safeguard that is necessary to protect the rights of the mentally ill. He expressed concern over the fact that Mr. Waldron stated that he would instruct people in how to use the law that affects Mr. Posey's liberty. He concluded by asking the committee to kill this bill.

Questions From Committee Members: None

Closing by Sponsor: Senator Keating stated that he has had experience with mental illness through friends and family. He said he finds it hard to believe that this little procedure can bring an indictment upon the whole mental illness program in Montana. He stated he could not determine where early commitment and prevention of severe mental illness was causing all the consequences of the mental illness program in the state. He stated he is at a loss to understand the opposition to the measure and he does not believe the effects of it warrant that impact. He asked the committee to leave

the safety valve in place for at least two more years.

DISPOSITION OF SENATE BILL 272

Discussion: None

Amendments and Votes: None

Recommendation and Vote: None

FURTHER DISCUSSION ON SB 124

Senator Hager advised that Senator Norman had asked someone to appear to answer questions regarding the aids patient being refused admittance to a care facility.

John Patrick, Department of Social and Rehabilitation Services, advised that the nursing homes cannot discriminate on the basis of diagnosis or handicap. However, they reserve the right to limit the types of patients that they can serve through their admission policy. He stated when their department got the call from the community hospital, he contacted two or three of the facilities in Missoula who indicated that their admission policies did not discriminate against an aids patient, but they were unable to take this particular patient, since they did not have a bed available that day. Their policy is to try to provide a private room for that type patient. From the SRS standpoint, ability to do any more to enforce that policy is fairly limited. If there truly was discrimination, the consequence could be that the Medicaid-Medicare funding could be terminated. At this point of time there is nothing of a lesser degree in the way of enforcement.

Mr. Patrick was asked if he felt the law was broken in the case, to which he stated he cannot really answer that. If they did have a private room available, it would suggest that they did not do all they could to admit the patient.

Janet Perkins, Supervisor at the Licensing Certification, stated that they have two mechanisms in place to address this. On the Federal side, Section 504 says the issue of the failure to admit aids patients is a civil rights question and all such allegations or issues are referred to the Office of Civil Rights. On the state side, in 50-5-105 it is stated that all phases of the operation of the health care facilities shall be without discrimination against anyone on the basis of race, creed, color, religion, national origin,

ROLL CALL

PUBLIC HEALTH

COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date 2/13/89

NAME	PRESENT	ABSENT	EXCUSED
Sen. Tom Hager	X		
Sen. Tom Rasmussen	X		
Sen. Lynch	X		
Sen. Himsl	X		
Sen. Norman	X		
Sen. McLane	X		
Sen. Pipinich	X		

Each day attach to minutes.

MENTAL DISABILITIES BOARD OF VISITORS

REPORT TO 1989 LEGISLATURE

(TEMPORARY) INVOLUNTARY COMMUNITY (OUT-PATIENT) COMMITMENT

SECTIONS 53-21-101 ET. SEQ.

The 1987 Legislature requested the Mental Disabilities Board of Visitors to provide a report on the community commitment bill (also called out-patient commitment) which was enacted as a temporary statute (House Bill 316) during the 1987 session.

TEMPORARY COMMUNITY COMMITMENT STATUTE

The temporary statute allows for involuntary community commitment of a person who is found to be "mentally ill" as defined by §53-21-102(8)(temp)MCA. The law is an attempt to address concerns regarding persons in the community who have a mental disorder which had not resulted in the person being a danger to himself or herself, or to others, but who's actions fit other criteria pointing to a serious deterioration in the person's condition and their disorder posed a significant risk that might eventually lead to the person becoming seriously mentally ill thus requiring hospitalization. The law mandates treatment in the community for persons who meet the definition of "mentally ill". It did not replace, but is in addition to, the regular 90-day involuntary mental health commitment provided for in Chapter 53. (The 90-day commitment statutes permit a person who is found to be "seriously mentally ill" and a danger to himself or others to be committed to the state hospital, a community mental health facility, an outpatient day program or any other treatment arrangement the court deems necessary.)

Because a person under the 30-day temporary statutes is not a danger to himself or others, the statutes permit the mentally ill person to be committed to a community mental health facility or program for inpatient or out-patient treatment but do not permit commitment to Montana State Hospital. Also, because the person is not an imminent danger and since detention is not considered beneficial for a person who's condition is deteriorating, the statutes do not permit detention prior to a hearing. Generally, if detention is needed because the person is a danger, the appropriate petition is a 90-day involuntary petition. The statutes provide that a community placement may last up to 30 days and may be extended one time during the commitment if the person continues to be "mentally ill".

SURVEY

The Board of Visitors staff have followed the use of this statute by talking with various mental health professionals, county attorneys, public defenders and agencies who are involved with mental health commitment issues. In December 1988, we conducted a survey of all mental health centers and county attorney offices and spoke to public defenders of various counties to see how effective they thought the temporary statutes were. From the survey we learned that:

(1) 41% of those responding reported that the statutes were "ineffective" or "totally ineffective" for various reasons including:

- * No funds available for community placement.
- * No community facilities available in many rural counties.
- * No resident judges, mental health professionals, doctors, etc., available in many rural counties.
- * For the amount of time and effort involved, they thought it was more efficient and clinically appropriate to seek a 90-day involuntary commitment petition.
- * Difficult criteria to meet and, if met, respondent is "usually bad enough to commit under a 90-day involuntary commitment".
- * If a facility is actually available in the community, it is often unwilling to "assume the risk".
- * There are no consequences to non-compliance.
- * The process is "too laborious given the questionable benefit".

(2) 39% of those responding either had no comment as to the effectiveness of the statutes or had not used it-either because use was not appropriate or beneficial or no situation had arisen which called for its' use. Typical comments included:

- * Never used. We have no facility for such community commitment.
- * Considered but decided not appropriate alternative to commitment or ...the evidence did not support a finding of "mentally ill".
- * Never had opportunity arise to use this.
- * Not used but looks as good as regular commitment although both are difficult in rural Montana because only one judge for several counties. Proper facilities often are not available or affordable.

(3) 20% of those responding thought that it was effective or somewhat effective in preventing serious deterioration. Typical comments included:

- * Effective if can be paid for privately. Useful if entire family cooperates.
- * Effective but in small rural counties access to judge, mental health professionals and services, including mental health centers, is limited. We have no local mental health center.
- * Definition is too restrictive - easier to prove "seriously mentally ill". Lots of hoops to jump through. May need detention.
- * Have not used but want to keep law "as a back-up" for when person is decompensating. Looks workable.
- * Good tool to attempt to prevent further deterioration. Need to become more familiar with it.

LEGISLATIVE ALTERNATIVES

The Board of Visitors sees two basic alternatives for this Legislature to consider regarding the temporary statutes.

Option 1 is to do nothing, in which case the temporary statute would sunset.

Option 2 is repeal the current sunset provision and either extend or delete any sunset provision.

We would note that a possible third alternative exists, revising the bill. However, if that revision involved a lessening of the standards, it would likely run afoul of constitutional standards which must be considered.

Recommendation:

Given the accumulated information on the temporary statutes, the Mental Disabilities Board of Visitors' recommendation would be to allow these statutes to sunset.

OFFICE OF THE GOVERNOR
MENTAL DISABILITIES BOARD OF VISITORS
LEGAL SERVICES PROGRAM



TED SCHWINDEN, GOVERNOR

P.O. BOX 177

STATE OF MONTANA

(406) 693-7035

SENATE HEALTH & WELFARE
EXHIBIT NO. 2
DATE 2/17/89
BILL NO. 272

TESTIMONY ON SENATE BILL 272
FEBRUARY 13, 1989 BY MARY GALLAGHER
BEFORE SENATE PUBLIC HEALTH COMMITTEE

Mr. Chairman, members of the committee, my name is Mary Gallagher and I am a staff attorney with the Mental Disabilities Board of Visitors legal services program. As Kelly Moore mentioned, the Board of Visitors was requested to report back to this Legislature regarding the 1987 House Bill 316. We sent a survey out to all the mental health centers and court attorneys. We spoke with some public defenders and others involved with commitments. As the report notes, approximately 41% of the results indicated the statutes were ineffective or totally ineffective; 39% of those responding either had no comment or had not used it because it was not appropriate or beneficial to the situation or else no situation had arisen which called for its use. 20% of those responding did think that the statute was effective or somewhat effective for its purpose. As a result of this survey and our further research discussed below, we would recommend that this committee vote against this bill and allow the out-patient commitment provisions to sunset.

You may hear the term 'outpatient' used in a variety of ways when people talk about mental health issues. I want to clarify that what we are talking about here in the underlying statutes should not be confused with:

1. Conditional Releases from an inpatient hospital like Warm Springs when a patient has been committed there on a 90-day involuntary petition after being found to be seriously mentally ill (that is, found to be an imminent threat of danger to self or others) or

2. Out-patient Commitment as Least Restrictive Alternative: Those same 90-day involuntary statutes require that a person committed under them must be committed to the least restrictive alternative to accomplish the treatment needs of the person-which could be out-patient treatment say, at a mental health center.

Perhaps the more accurate description for the statutes at issue in HB374 is that they require forced treatment in the community -that is 'preventive treatment' of persons who are not seriously mentally ill-the goal of the statutes being to prevent institutionalization before it happens and stop what has been called the revolving door syndrome.

The solution envisioned by these "preventive commitment" statutes is to prevent reinstitutionalization by forcing recalcitrant patients to accept treatment in the community. And this is to be accomplished by committing them to community

treatment before they meet the standards for involuntary inpatient commitment-that is before they become a danger to themselves or others.

The standards for preventive commitment contain a diminished set of due process protections. These standards apply to a person with a mental disorder whose actions fit criteria pointing to potential "serious deterioration" in the person's condition and the disorder poses a significant risk that might eventually lead to the person becoming seriously mentally ill and requiring hospitalization ...that is, a person seemingly caught in the revolving door syndrome.

The revolving door problem is a major mental health policy problem not only in Montana, but nation-wide. However, I believe proponents of this bill and of the underlying preventive commitment statutes are mistaken as to the source of the problem and also, therefore, as to its solution. It is our belief that any explanation for the revolving door phenomenon is much more complex than the singling out the usual targets of deinstitutionalization or so-called recalcitrant patients which are blamed for the problem.

It is necessary to examine some of the unarticulated assumptions of preventive commitment and this bill. The first is that the reason for the pattern of chronic rehospitalization among some patients is that these patients resist the very treatment--most often medications-- that will permit them to remain in the community. The second is the assumption that only the "treatment resistant" individual's mental illness leads him or her to the conclusion that medication is unnecessary. Third, they assume that failure to take medications is causally linked to deterioration, decompensation, psychosis, and reinstitutionalization. These assumptions essentially say that the patient is responsible for the failures and his or her ultimate return to an inpatient setting.

Despite these assumptions, one recent report states that: research shows that a substantial minority of mentally ill individuals will decompensate whether or not they receive medication; and that even more will improve whether or not they receive medication; and that these two groups combined constitute some 50% of the population of seriously mentally ill people. So the assumption that medication is necessary for the individual to prevent decompensation does not apply to at least half the targeted population of the out-patient commitment statutes, yet, the statutes force treatment on all individuals who meet the standards.

In addition, the report notes that many people who refuse medication have entirely understandable reasons for doing so which are not necessarily related to their mental illness, including fear of tardive dyskinesia, a disabling condition which will strike a substantial portion of people who take psychotropic medications on a regular basis, or neuroleptic malignant syndrome, which affects between 1% and 2.4% of individuals taking psychotropic medications and kills one out of four patients. Many patients simply cannot stand the side effects of psychotropic medications, which include akathisia(a distressing urge to move),

akinesia (inertia, inactivity, and lack of spontaneous movement), pseudo-Parkinsonism (causing retarded muscle movements, masked facial expression, body rigidity, tremor and a shuffling gait), muscle spasms, blurred vision, dry mouth, sexual dysfunction, drug-induced mental disorders and occasionally, sudden death. Stefan, Preventive Commitment: Misconceptions and Pitfalls in Creating a Coercive Community(1989).

The more accurate explanation involves a system of interlocking deficiencies that make it possible for all parties to shift the blame to each other. Such legislation exacerbates the problem and presents no lasting solution.

One recent article by an expert on out-patient commitment addresses how current mental health systems, such as Montana's, stack the odds against survival in the community. The article notes 5 areas which impede this survival. I think it is important to briefly mention these areas.

First, it notes the failure of institutions to provide adequate and realistic discharge plans for patients who leave the hospital.

Second, it notes the lack of affordable housing in the 80's due to the federal government policy of drastically reducing federally subsidized low income housing without a corresponding increase in the private sector and also notes the problems with reimbursement schemes by Medicaid and SSI which ultimately encourage institutionalization of the mentally ill instead of community treatment;

Third, it notes the failure of state mental health agencies to finance adequate community services such as trained crisis intervention, mobile treatment teams, case managers, and sufficient therapy and socialization programs. The bulk of state funding goes instead to the huge fixed expenses associated with institutional care.

Fourth, the article notes the tendency for community mental health centers to discriminate against the seriously mentally ill because of the tendency to prefer higher functioning, motivated clients who can pay for their services. Often the ones most in need of services are the ones who are provided with only a routine medication monitoring and no follow-up is done if a patient does not show up for an appointment.

Finally, the article notes the zoning and other discriminations in the community when an attempt is made to create neighborhood and community services and highlights the problems in dealing with the stigma of being mentally ill in our society.

Thrust into the community with no discharge planning and little chance of finding any housing, few individuals are a match for the battle with a hostile community, inadequate opportunities for training or education, and the absence of resources to provide mental health care in the community. There is little to do but struggle in poverty, since the supportive networks that may carry others through hardtimes are closed to many people recently discharged from institutions. We would ask, who among us could survive such isolation, poverty, and homelessness without "deterioration"?

Financing a system of preventive care is bound to increase the number of persons subject to commitment for treatment in the community. The outpatient commitment statutes which we are requesting be sunsetted, have failed to examine these problems, have failed to examine the adequacy of the existing resources and have failed to budget realistically to meet the increased demand created by such a statute.

The Board of Visitors survey also noted other difficulties with this law:

Monitoring is a problem. If the state orders a person to be treated involuntarily, it must ensure that the treatment is accomplishing its purpose. It is difficult to monitor the many scattered mental health centers because of their scattered sites plus this legislation provided no additional funding for such purposes.

Enforcement difficulties also exist. Since out-patient standards are necessarily different than for inpatient commitment, hospitalization may not be used as punishment for noncompliance. The most that can be done is to request a court order for the person to be examined to see if he meets the criteria for inpatient commitment.

The right of a competent person to consent to or refuse medications or other treatment is still a complicated and unresolved issue which is integrally tied to many out-patient commitments.

The concern for liability of treating professionals with their current limited ability to monitor the quality of treatment provided to persons on preventive commitments.

And finally, the important fact that the basic standard of deterioration which is part of the commitment criteria under our outpatient statute is constitutionally questionable. It has not been challenged in court yet but experts note that there is simply no precedent for depriving people of their liberty in order to treat them because they may need treatment in the future. Such commitments are questionable because the restriction on liberty is great and the government interest in providing unwanted treatment to competent non-dangerous adults simply does not have the same weight as its interest in hospitalizing those who are dangerous to self or others.

The single most common theme throughout the survey was the belief that such legislation was useless without adequate, available facilities in the community.

For all the above reasons the Board of Visitors recommends that you vote against this bill and encourages all involved to address a more wholesale solution to the complex problems of providing treatment to the mentally ill individuals of our state.

More than any tinkering with involuntary treatment criteria or modification of our civil commitment scheme, the actual availability of community programs would have the most dramatic impact on the current crisis in the mental health care. (Schwartz 1987)

Thank you.

2/13/89

DATE _____
PUBLIC HEALTH

VISITORS' REGISTER

[illegible]

(Please leave prepared statement with Secretary)

MINUTES

MONTANA SENATE 51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY

Call to Order: By Senator Tom Rasmussen, on February 15, 1989, at 1:00 p.m.

ROLL CALL

Members Present: Senators Tom Hager, Chairman; Tom Rasmussen, Vice-Chairman; J. D. Lynch, Matt Himsl, Bill Norman, Harry H. McLane, Bob Pipinich

Members Excused: None

Members Absent: None

Staff Present: Tom Gomez, Legislative Council
Dorothy Quinn, Committee Secretary

Announcements/Discussion: Senator Rasmussen announced that he would chair the meeting until Senator Hager returned from a hearing on a bill which he sponsors.

EXECUTIVE ACTION ON SENATE BILL 272

Vice-Chairman Rasmussen called for action on SB 272: This bill would remove the Sunset provision relating to the State Mental Health Involuntary Commitment Laws.

Discussion: Senator Norman stated the bill is a repealer of a Sunset provision. It addresses involuntary commitment to a community mental health facility on an in-patient or out-patient basis. He asked how that involuntary commitment would proceed. Tom Gomez addressed their attention to Title 53, the chapter that comprises the mental health statute. He gave an example of an adult who has a dependent child who must be committed for treatment, with the treatment not being necessary because of serious mental illness posing danger to themselves or others, but at a lower level of mental illness in which the person is certified as being an individual who suffers from mental illness. He further stated that if a person does not consent to commitment, then it becomes a civil matter. Senator Norman then asked if the professional person making the judgement would try to reach some opinion as to whether this person should be

involuntarily committed.

Senator Hager reminded the committee that Senator Keating had said the bill was a safety net, and used only when the regular rules did not take care of the matter.

Senator Rasmussen stated in this case he agrees with the Board of Visitors, which group was opposed to the bill.

Recommendation and Vote: Senator Rasmussen made a motion that SENATE BILL 272 DO NOT PASS. Senators in favor, 6; opposed, 0.

HEARING ON SENATE BILL 382

Presentation and Opening Statement by Sponsor: Senator Hager, Senate District #48, advised that he introduced this bill at the request of the Department. He stated it is an act to provide immunity from liability for Medical Ethics Review Committee members.

List of Testifying Proponents and What Group they Represent:

Jim Ahrens, Montana Hospital Association
Larry Akey, Montana Health Network

List of Testifying Opponents and What Group They Represent:

None

Testimony:

Jim Ahrens advised that one hospital in particular had asked his group to look at the confidentiality act that already is in place and there is some question as to whether or not discussions among medical ethics committees are subject to provisions of confidentiality. He stated that ethics committees undertake very serious discussions which have to be quite frank and straightforward. It is his group's feeling that those discussions should be protected and the bill is set up so that medical ethics review committees are included along with other peer review committees as the current statute provides. It is their hope that by including this the confidentiality will be maintained and the frankness of those discussions will continue. He urged passage of SB 382.

Larry Akey stated his group represents ten hospitals in eastern Montana. He said they support SB 382 for the reasons outlined by Mr. Ahrens, and asked that the committee pass this bill.

ROLL CALL

PUBLIC HEALTH

COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date 2/15/89

NAME	PRESENT	ABSENT	EXCUSED
Sen. Tom Hager	X		
Sen. Tom Rasmussen	X		
Sen. Lynch	X		
Sen. Hims1	X		
Sen. Norman	X		
Sen. McLane	X		
Sen. Pibinich	X		

Each day attach to minutes.

SENATE STANDING COMMITTEE REPORT

February 16, 1989

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety, having had under consideration SB 272 (first reading copy -- white), respectfully report that SB 272 do not pass.

DO NOT PASS

Signed: _____
Thomas O. Hager, Chairman

41. 6.84
11.61
10.34
10.10

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH

Date 2/15/89 Bill No. SB 272 Time 1:15

NAME	YES	NO
SEN. TOM HAGER	X	
SEN. TOM RASMUSSEN	✓	
SEN. LYNCH	absent	
SEN. HIMSL	X	
SEN. NORMAN	X	
SEN. McLANE	X	
SEN. PIPINICH	X	

Louise Sullivan
Secretary

Sen. Tom Hager
Chairman

Motion: Motion by Rasmussen
A 6 DO NOT PASS
Unanimous
6 in favor - 0 opposed

Proponent Testimony:

JoAnn McLeod told of the hardship of transporting her daughter to sheltered workshops.

Dennis Taylor stated that he supports this bill.

Testifying Opponents and Who They Represent:

None.

Opponent Testimony:

None.

Questions From Committee Members: Rep. Russell asked Senator Lynch if this bill was originally for DD clients who did not have transportation and the bill had been amended and Senator Lynch stated yes.

Rep. Boharski asked Senator Lynch if amending this bill to state that funds will not be given if this program is already being funded by another federal or state program and Senator Lynch stated that he did not object.

Rep. Simon asked Senator Lynch about bus modification and questioned if there were any provisions that would try to help put something together to modify another bus and Senator Lynch stated that he had checked into this situation and in turn spoke with different contractors who stated that they would do the service but at a very high price. Rep. Simon then questioned ambulance service as a means of transportation.

Rep. Good asked Senator Lynch if a family member is ever reimbursed for transporting and Senator Lynch stated that he could be.

Closing by Sponsor: Senator Lynch closed on the bill.

HEARING ON SB 272

Presentation and Opening Statement by Sponsor:

Senator Keating stated that this bill was an act to extend the sunset provision relating to the state mental health involuntary commitment laws and providing an immediate effective date.

Testifying Proponents and Who They Represent:

Steve Waldron, Montana Council of Mental Health Centers
Don Harr, Region 3 Mental Health Center

Proponent Testimony:

Steve Waldron submitted testimony which stated why there is a need for this type of involuntary commitment; what is the community commitment law; why hasn't the law been used more and what are the safeguards in the community commitment law. Exhibit 4.

Don Harr stated that he had both direct and indirect opportunity to recognize the value of this opportunity for a 30 day commitment with what can be used as a one extension of 30 days if necessary, all of which has to be approved by the court.

Testifying Opponents and Who They Represent:

Kelly Moore, Montana Board of Visitors
Mary Gallagher, Montana Board of Visitors

Opponent Testimony:

Kelly Moore submitted a copy of the temporary community commitment statute. Exhibit 5.

Mary Gallagher stated that the solution envisioned by new statutes is to prevent reinstitutionalization by forcing recalcitrant patients to accept treatment in the community. This was supposedly to be done before they deteriorate to the point that they meet the standards for involuntary inpatient commitment. Exhibit 6.

Questions From Committee Members: Rep. Gould asked Mr. Waldron if it were a true statement to say that it takes a considerable amount of time for people to understand them and realize that they are out there and Mr. Waldron stated that it was true.

Rep. Stickney asked Dr. Harr if there tends to be more frustration for those who seek care for someone who is deteriorating, would you concur it to be too important to let go and Dr. Harr said that he did in fact agree.

Closing by Sponsor: Senator Keating closed on the bill.

HEARING ON SB 289

Presentation and Opening Statement by Sponsor:

Senator Hager stated that this bill was an act authorizing an increase in the term of a lease of a county nursing home to allow a sufficient term to finance mandated health and safety improvements and providing an immediate effective date.

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date 3/8/89

NAME	PRESENT	ABSENT	EXCUSED
Hella Jean Hansen	✓		
Bill Strizich	✓		
Robert Blotkamp	✓		
Jan Brown	✓		
Lloyd McCormick	✓		
Angela Russell	✓		
Carolyn Squires	✓		
Jessica Stickney	✓		
Timothy Whalen	✓		
William Boharski	✓		
Susan Good	✓		
Budd Gould	✓		
Roger Knapp	✓		
Thomas Lee	✓		
Thomas Nelson	✓		
Bruce Simon	✓		

MONTANA COUNCIL OF
MENTAL HEALTH CENTERS

512 LOGAN
HELENA, MT 59601
(406) 442-7808

EXHIBIT 48
DATE 3-18-89
HB 272

FACT SHEET
SB 272 - REPEAL SUNSET
COMMUNITY COMMITMENT LAW

I. WHY IS THERE A NEED FOR THIS TYPE OF INVOLUNTARY COMMITMENT?

Under the current law a mentally ill person must be a clear and imminent danger to himself or others in order to be involuntarily committed for treatment as "seriously mentally ill." The law requires that the "seriously mentally ill" individual must have committed a recent and overt action to be classed as "seriously mentally ill" and to be committed for treatment.

A mentally ill person, who needs treatment and is very sick and deteriorating, often does not meet the current legal definition of "seriously mentally ill". For instance, a client in a day treatment program who suddenly stops taking care of himself including eating, may not meet the definition of "seriously mentally ill." The client may even be hearing voices telling him (her) to do violent acts. Even though the person is obviously deteriorating and requires treatment, there is nothing that can be done until the individual commits some overt act to be declared "seriously mentally ill." However, intervention may be possible under the Community Commitment Law.

II. WHAT IS THE COMMUNITY COMMITMENT LAW?

An additional definition, "mentally ill," was added to the current commitment law by the 1987 legislature. The court could commit a "mentally ill" person only to a community facility for a very limited time with the intention of getting the person quickly stabilized and able to function in the community.

In order to be committed to a community facility under this additional definition, the "mentally ill" person has to meet all the following criteria - The person has to be suffering from a mental disorder which:

(1) has resulted in behavior that creates serious difficulty in protecting the person's life or health even with available assistance from family, friends, or others;

(2) is treatable, with a reasonable prospect of success and consistent with the least restrictive course of treatment, at or through the community facility to which the person is to be committed;

REGION I
EASTERN MONTANA COMMUNITY
MENTAL HEALTH CENTER
1515 MAIN STREET
BOZEMAN, MONTANA 59717
(406) 552-0044

REGION II
GREAT SOUTHERN COMMUNITY
MENTAL HEALTH CENTER
HOLIDAY VILLAGE SHOPPING CENTER
PO BOX 600
GREAT FALLS, MONTANA 59403
(406) 761-1111

REGION III
CENTRAL MONTANA COMMUNITY
MENTAL HEALTH CENTER
1111 NORTH 29TH STREET
GREAT FALLS, MONTANA 59403
(406) 761-1111

REGION IV
CENTRAL MONTANA COMMUNITY
MENTAL HEALTH CENTER
512 LOGAN
HELENA, MONTANA 59601
(406) 442-7808

REGION V
WESTERN MONTANA COMMUNITY
MENTAL HEALTH CENTER
FORT MISSOULA 710
MISSOULA, MONTANA 59801
(406) 683-0001

(3) has deprived the person of the capacity to make an informed decision concerning treatment;

(4) has resulted in the person's refusing or being unable to consent to voluntary admission for treatment; and

(5) will, if untreated, predictably result in further serious deterioration in the mental condition of the person or poses significant risk of the person's becoming seriously mentally ill. Predictability may be established by the patient's medical history.

III. WHY HASN'T THE LAW BEEN USED MORE?

The Community Commitment Law was never intended to be used as an extensive or exclusive method of dealing with those mentally ill persons who are beginning to deteriorate. The Community Commitment process should only be utilized for those mentally ill persons who meet the above criteria and are likely to benefit from a short term intervention to be maintained in the community.

The law has only been in effect since October 1, 1987 and therapist's have been cautious in attempting to use this law. There has not been sufficient education of many therapists on this new law. In addition, self education is difficult because the Community Commitment Law is poorly codified in Title 53, Chapter 21. It is extremely difficult to read and interpret because it is scattered throughout chapter 21. A recodification has been requested.

IV. WHAT ARE THE SAFEGUARDS IN THE COMMUNITY COMMITMENT LAW?

1. The commitment procedure requires a court hearing in which the person will be represented by an attorney.

2. The court must hold an initial hearing on the petition for commitment within 5 days.

3. The court must appoint a professional to evaluate the person who is alleged to be "mentally ill".

4. The person alleged to be "mentally ill" can also receive an additional evaluation by a professional person of his (her) choice.

5. The person may not be detained until after a hearing is held, a determination is made, and a court order is issued committing the person for treatment.

6. The person who is alleged to be "mentally ill" can demand a jury be impaneled to hear the case.

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7. The person has the right to know in advance of the hearing the names of the witnesses who will testify.

8. To be committed the person must meet all of the criteria to be adjudicated as being "mentally ill." (See item II above for a list of the criteria.)

9. In order to require treatment which includes medication the court must make a separate finding and make a separate order for medication. However, the court may not order the use of physical force to administer medication.

11. The person can only be committed to a community facility for a 30 day period. There can be only one extension of the 30 day period for an additional 30 days.

12. The person declared to be "mentally ill" retains other safeguards such as the right to appeal the court decision.

MENTAL DISABILITIES BOARD OF VISITORS

REPORT TO 1989 LEGISLATURE

(TEMPORARY) INVOLUNTARY COMMUNITY (OUT-PATIENT) COMMITMENT

SECTIONS 53-21-101 ET. SEQ.

The 1987 Legislature requested the Mental Disabilities Board of Visitors to provide a report on the community commitment bill (also called out-patient commitment) which was enacted as a temporary statute (House Bill 316) during the 1987 session.

TEMPORARY COMMUNITY COMMITMENT STATUTE

The temporary statute allows for involuntary community commitment of a person who is found to be "mentally ill" as defined by §53-21-102(8)(temp)MCA. The law is an attempt to address concerns regarding persons in the community who have a mental disorder which had not resulted in the person being a danger to himself or herself, or to others, but who's actions fit other criteria pointing to a serious deterioration in the person's condition and their disorder posed a significant risk that might eventually lead to the person becoming seriously mentally ill thus requiring hospitalization. The law mandates treatment in the community for persons who meet the definition of "mentally ill". It did not replace, but is in addition to, the regular 90-day involuntary mental health commitment provided for in Chapter 53. (The 90-day commitment statutes permit a person who is found to be "seriously mentally ill" and a danger to himself or others to be committed to the state hospital, a community mental health facility, an outpatient day program or any other treatment arrangement the court deems necessary.)

Because a person under the 30-day temporary statutes is not a danger to himself or others, the statutes permit the mentally ill person to be committed to a community mental health facility or program for inpatient or out-patient treatment but do not permit commitment to Montana State Hospital. Also, because the person is not an imminent danger and since detention is not considered beneficial for a person who's condition is deteriorating, the statutes do not permit detention prior to a hearing. Generally, if detention is needed because the person is a danger, the appropriate petition is a 90-day involuntary petition. The statutes provide that a community placement may last up to 30 days and may be extended one time during the commitment if the person continues to be "mentally ill".

SURVEY

The Board of Visitors staff have followed the use of this statute by talking with various mental health professionals, county attorneys, public defenders and agencies who are involved with mental health commitment issues. In December 1988, we conducted a survey of all mental health centers and county attorney offices and spoke to public defenders of various counties to see how effective they thought the temporary statutes were. From the survey we learned that:

(1) 41% of those responding reported that the statutes were "ineffective" or "totally ineffective" for various reasons including:

- * No funds available for community placement.
- * No community facilities available in many rural counties.
- * No resident judges, mental health professionals, doctors, etc., available in many rural counties.
- * For the amount of time and effort involved, they thought it was more efficient and clinically appropriate to seek a 90-day involuntary commitment petition.
- * Difficult criteria to meet and, if met, respondent is "usually bad enough to commit under a 90-day involuntary commitment".
- * If a facility is actually available in the community, it is often unwilling to "assume the risk".
- * There are no consequences to non-compliance.
- * The process is "too laborious given the questionable benefit".

(2) 39% of those responding either had no comment as to the effectiveness of the statutes or had not used it-either because use was not appropriate or beneficial or no situation had arisen which called for its' use. Typical comments included:

- * Never used. We have no facility for such community commitment.
- * Considered but decided not appropriate alternative to commitment or ...the evidence did not support a finding of "mentally ill".
- * Never had opportunity arise to use this.
- * Not used but looks as good as regular commitment although both are difficult in rural Montana because only one judge for several counties. Proper facilities often are not available or affordable.

(3) 20% of those responding thought that it was effective or somewhat effective in preventing serious deterioration. Typical comments included:

- * Effective if can be paid for privately. Useful if entire family cooperates.
- * Effective but in small rural counties access to judge, mental health professionals and services, including mental health centers, is limited. We have no local mental health center.
- * Definition is too restrictive - easier to prove "seriously mentally ill". Lots of hoops to jump through. May need detention.
- * Have not used but want to keep law "as a back-up" for when person is decompensating. Looks workable.
- * Good tool to attempt to prevent further deterioration. Need to become more familiar with it.

LEGISLATIVE ALTERNATIVES

The Board of Visitors sees two basic alternatives for this Legislature to consider regarding the temporary statutes.

Option 1 is to do nothing, in which case the temporary statute would sunset.

Option 2 is repeal the current sunset provision and either extend or delete any sunset provision.

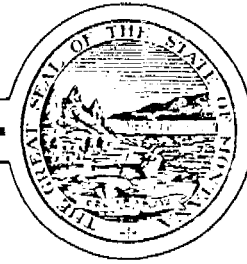
We would note that a possible third alternative exists, revising the bill. However, if that revision involved a lessening of the standards, it would likely run afoul of constitutional standards which must be considered.

Recommendation:

Given the accumulated information on the temporary statutes, the Mental Disabilities Board of Visitors' recommendation would be to allow these statutes to sunset.

EXHIBIT _____
DATE _____
HB _____

OFFICE OF THE GOVERNOR
MENTAL DISABILITIES BOARD OF VISITORS
LEGAL SERVICES PROGRAM



TED SCHWINDEN, GOVERNOR

P.O. BOX 177

STATE OF MONTANA

(406) 693-7035

WARM SPRINGS, MONTANA 59756

TESTIMONY ON SENATE BILL 272
BY MARY GALLAGHER BEFORE THE HOUSE HUMAN SERVICES
AND AGING COMMITTEE
ON MARCH 8, 1989

Mr. Chairman, Members of the Committee, my name is Mary Gallagher and I am a staff attorney for the Mental Disabilities Board of Visitors Program. As Kelly Moore mentioned, the Board of Visitors staff was requested to report back to the Legislature regarding the 1987 House Bill 316 which created these outpatient commitment statutes. You have all been provided with a copy of our report. I would like to briefly go over our survey and mention a few reasons why I do not think this bill should pass.

We sent the survey to all the mental health centers and county attorneys in the State. As the report notes, approximately 41% of those responding indicated that these statutes were ineffective or totally ineffective for various reasons including lack of community facilities, lack of funds for placement in the community, stringent commitment criteria, etc.

39% of those responding either had no comment as to its effectiveness or had not used it because use was not appropriate or no situation had arisen which called for its use.

20% of those responding to the survey thought that the statutes were effective or somewhat effective. This group mentioned that payment, lack of facilities, and the commitment criteria were problems but thought the law was a good back-up and could be used to prevent deterioration.

The solution envisioned by these and other "preventative commitment" statutes is to prevent reinstitutionalization by forcing "recalcitrant" patients to accept treatment in the community. This was supposedly to be done before they deteriorate to the point that they meet the standards for involuntary inpatient commitment. In Montana that means this occurs before they become a danger to themselves or to others.

There are all kinds of potential problems with a commitment standard which would deprive a person of liberty when that person is not a danger to anyone. But beyond this, proponents of this bill and of the community commitment statutes are mistaken as to the source of the underlying "revolving door" problem and so their proposed solution is also inappropriate and ineffective. Forced community commitment places blame on the so-called

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"recalcitrant" patient instead of on the system which does not provide the programs and community alternatives necessary to maintain the person in the community. As one expert on the subject states, the revolving door phenomenon involves a "system of interlocking deficiencies that make it possible for all parties to shift the blame to each other. Legislation forcing community treatment presents no lasting solution." Stefan, Preventative Commitment: Misconceptions and Pitfalls in Creating a Coercive Community.

In addition to this, there are also a number of problems specific to our Statutes. For example, there is difficulty monitoring a patient in the community; there are enforcement difficulties when someone does not comply; there is potential liability of community professionals for those people committed to the community; there is a problem with the constitutional questionability of the "deterioration" standard. And finally, the preventative commitment legislation is useless without the existence of community facilities and the money to pay for them. More than any tinkering with civil commitment statutes, the actual availability of community programs would have the most dramatic impact on the problem the proponents are trying to address.

The underlying bills do not work. The survey we did bares this out. For all of the above reasons, we recommend that you vote against this bill and let those statutes sunset.

Thank you.

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HB _____

HUMAN SERVICES AND AGING

BILL NO.

DATE _____

SPONSOR

[illegible]

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

with the exception of Reps. Hansen, Whalen, Russell, Strizich and Squires. Motion carries.

DISPOSITION OF SB 272

The Hearing on SB 272 was held on March 8, 1989.

Motion: Rep. Boharski made a Motion TO BE CONCURRED IN.

Amendments, Discussion, and Votes: Rep. Gould made a Motion to amend the effective date to 1996 which was later changed to 1997. A vote was taken and all voted in favor.

Recommendation and Vote: Rep. Gould made a Motion TO BE CONCURRED IN AS AMENDED. A vote was taken and all voted in favor. Motion carries.

DISPOSITION OF SB 311

The Hearing on SB 311 was held on March 13, 1989.

Motion: Rep. Good made a Motion TO BE CONCURRED IN.

Amendments, Discussion, and Votes: Rep. Simon made a Motion to move the amendments. A vote was taken and all voted in favor.

Recommendation and Vote: Rep. Simon made a Motion to BE CONCURRED IN AS AMENDED. A vote was taken and all voted in favor. Motion carries.

DISPOSITION OF SB 352

Motion: Rep. Gould made a Motion TO BE CONCURRED IN.

Discussion: Rep. Whalen stated that the bill should be referred to an interim subcommittee study resolution be adopted.

Rep. Good inquired on the fiscal note.

Rep. Nelson inquired on the statement of intent.

Amendments, Discussion, and Votes: Rep. Simon made a Motion to move the amendments. A vote was taken and all voted in favor. Rep. Good stated that the amendments were not extensive enough to cover the cost. Rep. Hansen stated that the Department already had an adoption department and the funding would be covered under this. Rep. Knapp stated that the Department was already established for adoption of children between 1 and 18 but the new bill would enable the adoption of infants.

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date March 15, 1989

NAME	PRESENT	ABSENT	EXCUSED
Stella Jean Hansen	✓		
Bill Strizich	✓		
Robert Blotkamp	✓		
Jan Brown	✓		
Lloyd McCormick	✓		
Angela Russell	✓		
Carolyn Squires	✓		
Jessica Stickney	✓		
Timothy Whalen	✓		
William Boharski	✓		
Susan Good	✓		
Budd Gould	✓		
Roger Knapp	✓		
Thomas Lee	✓		
Thomas Nelson	✓		
Bruce Simon	✓		

STANDING COMMITTEE REPORT

March 16, 1989

Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging
report that Senate Bill 272 (third reading copy -- blue) be
concurrent in as amended.

Signed: _____
Stella Jean Hansen, Chairman

[REP. ADDY WILL CARRY THIS BILL ON THE HOUSE FLOOR]

And, that such amendments read:

1. Page 1, line 16.
Strike: "1991"
Insert: "1997"